BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2011-798
MICHELLE SIVILLA **44 Gingham Street** **Trabuco Canyon, CA 92679** **Registered Nurse License No. 529559** Respondent.	**DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about March 22, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-798 against Michelle Sivilla (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about February 6, 1997, the Board of Registered Nursing (Board) issued Registered Nurse License No. 529559 to Respondent. The Registered Nurse License expired on April 30, 2008, and has not been renewed.

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3. On or about March 22, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2011-798, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board, which was and is: 44 Gingham Street, Trabuco Canyon, CA 92679.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about March 28 and 29, 2011, the aforementioned documents were returned by the U.S. Postal Service marked "Attempted Not Known." The address on the documents was the same as the address on file with the Board. Respondent failed to maintain an updated address with the Board and the Board has made attempts to serve the Respondent at the address on file. Respondent has not made herself available for service and therefore, has not availed herself of her right to file a notice of defense and appear at hearing.

6. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-798.

8. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

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9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2011-798, finds that the charges and allegations in Accusation No. 2011-798, are separately and severally, found to be true and correct by clear and convincing evidence.

10. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is $8,091.25 as of April 18, 2011.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Michelle Sivilla has subjected her Registered Nurse License No. 529559 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Respondent has subjected her license to disciplinary action under Business and Professions Code section 2761(a)(1) within the meaning of California Code of Regulations, title 16, section 1443.5, for unprofessional conduct and incompetence.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 529559, heretofore issued to Respondent Michelle Sivilla, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 22, 2011.

It is so ORDERED June 23, 2011.

Jeannie K. Lee

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

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DOJ Matter ID: SD2010703108

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
ERIN M. SUNSERI
Deputy Attorney General
State Bar No. 207031
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2071
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHELE SIVILLA, aka** **MICHELE HUNTER; and** **MICHELE IOIMO** 44 Gingham Street Trabuco Canyon, CA 92679 Registered Nurse License No. 529559 Respondent.	Case No. 2011-798 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 6, 1997, the Board of Registered Nursing issued Registered Nurse License Number 529559 to Michelle Sivilla (Respondent). The Registered Nurse License expired on April 30, 2008, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

7. Section 2761 of the Code states, in pertinent part: .

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

10. On or about March 3, 2005, patient FT was admitted to the telemetry unit at Mission Hills Hospital in Orange County, California. She was admitted for Sickle Cell crisis, severe pain, possible lower respiratory infection, and possible urinary tract infection.

11. Patient FT's plan of care included pain control with morphine (a narcotic used for pain control) utilizing a PCA[1] , telemetry monitoring and continuous pulse oximetry[2] monitoring.

12. On or about March 5, 2005, at approximately 1:00 a.m., patient FT was found unresponsive with an oxygen saturation level of 54-56% (a normal oxygen saturation level is 92-100%). A code blue was called, and the patient was revived with breathing support (bag mask with oxygen) and Narcan.[3]

13. Immediately after the administration of Narcan, patient FT was very agitated and complaining of severe pain. Respondent contacted patient FT's physician and reported that patient FT had coded, Narcan was given, and the patient was "screaming in pain." The PCA was stopped during the code, and restarted at a lower continuous rate at or about 1:30 a.m.

14. At or about 6:00 a.m., patient FT became sleepy and Respondent turned off the PCA and administered *another* dose of Narcan.

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[1] Patient Controlled Analgesia-a machine that allows the patient to push a button to deliver pain medication, such as morphine. The PCA has safety mechanisms in place to prevent overdose, and has a continuous option which delivers a small continuous dose. **When a patient is on a PCA, their oxygen saturation must be continuously monitored, because medications such as morphine can depress respiratory function and decrease oxygen saturation levels.**

[2] Pulse oximetry is a mechanism that is applied to a patient's finger and which gives a read of the patient's oxygen saturation level.

[3] Narcan is a medication that reverses the sedating effects of narcotics such as morphine. It is given to patients who experience severe respiratory depression from narcotics. Narcan's reversal effects wear off sooner than the narcotics; therefore, **after treatment with Narcan the patient must be closely monitored for reoccurrence of respiratory depression.**

15. At or about 7:00 a.m., patient FT was found to be nonresponsive and was taken for a cat scan, and subsequently transferred to ICU, where she remained in a comatose state and suffered other complications, including a permanent brain damage and subsequent disability.

16. Despite a physician's order for continuous pulse oximetry monitoring and oxygen for patient FT, she was neither wearing oxygen nor a continuous pulse oximeter on the night of this incident, without explanation.

17. The accepted standard of practice for a Registered Nurse is to follow physicians' orders or address issues of noncompliance in the medical record.

18. Failure to follow an order for oxygen and pulse oximetry monitoring can cause a patient harm if the oxygen level decreases and it goes unnoticed. Patient FT's medical record lacks evidence of follow up assessments on patient FT for several hours after administration of Narcan for respiratory depression and a severe decrease in oxygen saturation level. Patient FT's medical record lacks evidence of Respondent checking or recording vital signs, including oxygen saturation, for hours at a time. Respondent should have monitored Patient FT more frequently, and documented the outcomes in Patient FT's medical record.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent's license is subject to disciplinary action under Business and Professions Code section 2761(a)(1) within the meaning of California Code of Regulations, title 16, section 1443.5, on the grounds of unprofessional conduct, as follows:

a. Respondent did not follow physicians' orders to apply oxygen and to monitor patient FT's oxygen saturation level by utilizing continuous pulse oximetry, as detailed above in paragraphs 10-18, and incorporated herein by reference;

b. Respondent neglected to recheck Patient FT's respiratory function, vital signs, and oxygen saturation levels appropriately after administration of Narcan, as detailed above in paragraphs 10-18, and incorporated herein by reference.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 529559, issued to Michelle Sivilla;

2. Ordering Michelle Sivilla to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/22/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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